moderate CD, defined as CDAI ≤300 at Wk 4, were analysed. A Cox model was applied to analyse the association between Wk-4 CRP concentration and the probability of having a CD-related hospitalisation during the 52-wk double-blind period. Wk-4 CDAI score, Wk-4 steroid use, age, sex, weight, body mass index, and prior anti–tumour necrosis factor use were also adjusted in the model. Patients were censored if they switched to open-label adalimumab or dropped out. A receiver operating characteristic (ROC) curve was used to identify the optimal CRP cut-off point to best predict the 52-wk CD-related hospitalisation rate.

Results The analysis population included 214 patients randomised to placebo with Wk-4 CDAI ≤300. An elevated Wk-4 CRP concentration was associated with a greater chance of CD-related hospitalisation (HR=1.24; p=0.002). The ROC curve identified a CRP concentration =1.41 mg/dl as the dichotomising point (area under the curve=0.68; sensitivity=0.58; specificity=0.80). Risk of CD-related hospitalisation during the double-blind period was 3.4 times greater for patients with CRP concentrations ≥1.41 mg/dl at Wk 4 vs patients with CRP concentrations <1.41 mg/dl (p=0.015), with control for CDAI and other covariates.

Conclusion Early CRP concentration represents a moderate to good marker to predict CD-related hospitalisation for patients with moderately active CD given the same CDAI score. CRP concentration of 1.41 mg/dl was the optimal cut-off point for predicting long-term CD-related hospitalisation.

Competing interests J-F Colombel Consultant for: Abbott, Speaker bureau with: Abbott, W Sandborn Grant/Research Support from: Abbott, Consultant for: Abbott, E Louis Speaker bureau with: Abbott, Conflict with: Abbott, R Panaccione Grant/Research Support from: Abbott, Consultant for: Abbott, Speaker bureau with: Abbott, Conflict with: Abbott, R Thakkar Shareholder with: Abbott, Employee of: Abbott, M Castillo Shareholder with: Abbott, Employee of: Abbott, M Yang Shareholder with: Abbott, Employee of: Abbott, T Finney-Hayward Shareholder with: Abbott, Employee of: Abbott, J Chao Shareholder with: Abbott, Employee of: Abbott, P Mulani Shareholder with: Abbott, Employee of: Abbott.

REFERENCE

1. **Henriksen M**, *et al*. *Gut* 2008;**57**:1518–23.

PWE-261 HAVE YOU HEARD OF THE TRUELOVE AND WITTS CRITERIA? ACUTE SEVERE ULCERATIVE COLITIS MANAGEMENT BY FY1 DOCTORS

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Introduction Acute severe ulcerative colitis (UC) is a serious illness that requires prompt hospitalisation and is associated with significant morbidity. It requires intensive monitoring, specialist intervention and a multidisciplinary approach throughout the duration of the illness with timely and appropriate medical and surgical interventions to avoid complications. Our aim was to evaluate the Foundation Year 1 (FY1) doctor's knowledge and understanding of this potentially life threatening emergency.

Methods We approached FY1 doctors with an example case of acute severe UC and a questionnaire asking several questions regarding the diagnosis and management of acute severe UC 5 months into their training in 2011.

Results 48 FY1 doctors completed the questionnaire during a medical teaching session. Only 25% had heard of the Truelove and Witts criteria as a tool for assessing the severity of UC. When asked regarding the criteria, 77.08% recognised stool frequency as one, 72.91% heart rate, 62.5% temperature, 41.67% haemoglobin and 35.42% erythrocyte sedimentation rate (ESR) as part of it. 58.33% of those asked diagnosed the example case as an acute severe UC, however only 43.75% stated that they would request daily abdominal x-rays as part of their management plans. 62.5% of those asked knew intravenous corticosteroid therapy was mainstay of the initial treatment. 72.92% answered correctly regarding the use of thromboprophylaxis as standard therapy in the management of the condition and 79.17% said they would regularly check the serum potassium level during the course of the presentation.

Conclusion This study highlights the lack of knowledge and understanding of the diagnosis and management of acute severe UC by the FY1s. We would recommend a more structured approach to teaching regarding the condition at all levels of training during planned sessions. Protocols for admission and management of acute UC and local acute medicine hospital guidelines may aid education and bridge gaps in knowledge.

Competing interests None declared.

General liver II

PWE-262 PREVALENCE OF HARMFUL, HAZARDOUS OR DEPENDENT DRINKING IN HOSPITAL INPATIENTS ON A SINGLE DAY USING AUDIT QUESTIONNAIRE

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Introduction Deaths from alcoholic liver disease have increased dramatically. Currently, 24% of UK adults are said to drink in a harmful or hazardous manner. The government strategy to combat alcohol mortality (NICE PH24)[1] includes widespread screening using validated questionnaires such as AUDIT (Alcohol Use Disorders Identification Test).[2] Previous studies in hospitals have been with selected patients & and it is not clear how many patients in hospital are high risk drinkers. We performed a "snap shot" study of all inpatients at a single hospital on a single day using the AUDIT questionnaire to assess prevalence of high risk drinking and the feasibility of such widespread screening.

Methods All adult inpatients on a single day at Peterborough City Hospital were asked to participate. Two consultants, a nurse specialist and 30 clinical medical students used the AUDIT questionnaire to assess patients for harmful, hazardous or dependent drinking. The AUDIT questionnaire consists of 10 questions with a maximum score of 40. A score of 0–7 indicates low risk, 8–15 indicates harmful drinking, 16–19 indicates hazardous drinking and >20 indicates dependent drinking. Patients scoring >8 were then offered a brief intervention.

Results Of a total of 490 patients, AUDIT scores were obtained on 380 (78%); 110 (22%) could not be assessed because of confusion or illness. The age range was 17–99 years (mean 69). Scores ranged from 0/40 to 38/40. Of 380 inpatients who were assessed, 40 (10.5%) scored > or equal to 8/40 indicating harmful, hazardous or dependent drinking. 1.6% (6/380) scored >20 (dependent drinking), 7.4% (28/380) scored 16–19 (hazardous drinking) and 1.6% (6/380) scored 8–15 (harmful drinking). 89.5% (340/380) were low risk (score 0–7). Patients at risk (scoring 8 or above) were distributed across hospital wards and included 17% of females on the maternity ward, 13% on an orthopaedic ward and 12% on the respiratory ward.

Conclusion We have demonstrated that 10.5% of adult hospital inpatients are drinking in a harmful, hazardous or dependent manner. They were scattered throughout the hospital and not in any particular speciality. This prevalence is lower than the 24% in the UK population, perhaps due to the higher age of hospital patients. 22% of patients could not be assessed on the day of the study. However, our results suggest that the AUDIT questionnaire is a useful tool to identify patients at risk of alcohol related problems and is a feasible undertaking.

Competing interests None declared.